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Good morning. I am pleased to have the opportunity to discuss our experiences at Pitney Bowes, and how our successes present a workable set of principles for managing one of the most important domestic issues facing not only the United States, but the entire developed world.

I would summarize Pitney Bowes' 17-year journey to develop a culture of health as follows: By actively investing in health and in helping those with health problems manage their medical conditions we have been successful in health cost increases well below market averages, and in improving the health and the productive capacity of our employees. In fact, for many years during the 1990's and in recent years, our health costs --among our populations in our facilities -- were flat from year to year, and significantly below other companies with which we benchmark. We have shared the savings with our employees in the form of investments in our culture of health. Because of our investments in their health, those productive employees are more engaged in delivering economic value to customers and shareholders.

The cost side of the health care equation certainly impacts the global competitiveness of our economy and of businesses across America. Because of our exceptionally high and fast-increasing health care costs, government officials, payers such as employers and individuals, and other stakeholders are preoccupied with the question of making sure that there is universal

coverage at more affordable rates. But the fundamental question before we look at coverage and the distribution of costs to insure affordability is "why are we spending more and more?"

The answer is simple. American health costs are skyrocketing because American health is deteriorating, and the majority of health care costs are being incurred for preventable and controllable chronic and infectious diseases. The implicit assumption in our health care policies, laws, and regulations and the current predominant focus on solving the universal coverage problem is the opposite: that most health care arise from unpreventable, unforeseeable, uncontrollable medical conditions randomly visited upon people. Getting the answer to this question right matters a great deal. If we focus predominantly on expanding affordable coverage, but do not address the underlying health issue, eventually the cost of health care will not be affordable for anyone but the rich, and we will be facing ugly and divisive issues of rationing of care.

Fortunately, the reality is different:

- Preventable chronic diseases like diabetes, cardio-vascular diseases, and hypertension comprise the highest percentage of our health care costs, and according to the Centers for Disease Control and Prevention, account for 7 of every 10 deaths in the United States and affect the quality of life for over 100 million Americans. These conditions either result from obesity or from other lifestyle-related behaviors such as smoking and alcohol abuse, and our health care burden for them is rapidly growing.

- There is also a significant increase in a wide range of treatable behavioral health conditions, such as substance abuse and clinical depression pathologies. Not only does the direct treatment of these conditions cost a great deal, but they inhibit those with them who have other chronic diseases from adhering to treatment plans for those other diseases.
- There is also a crisis with respect to preventable infectious diseases. Besides the obvious broad problem of HIV/AIDS, we are also seeing a resurgence of tuberculosis and other infectious diseases once believed to be under control. MRSA has been in the news, because it is a strain of antibiotic resistant bacteria that is occurring more frequently outside of hospitals in places such as schools. It has also highlighted the fact that we cannot solve our health problems by expecting the next silver-bullet antibiotic. None exist, but we can take prudent steps to prevent and contain the spread of infectious diseases.
- There has been a great deal of media attention on flu pandemics, but in an average year, 200,000 Americans die from seasonal influenza. We have the ability to reduce both the incidence and the seriousness of influenza, but the majority of Americans do not avail themselves of the opportunity to get annual immunizations.
- Other conditions like asthma and emphysema, which are either induced or made worse by man-made environmental conditions, continue to grow. These environmental conditions are reversible, particularly if we take the same actions that will address carbon footprint issues, such as reducing motor vehicle gasoline consumption.

Even acute care conditions like cancer which we are not certain we know how to prevent are more manageable and far less expensive to treat if they are caught early through diagnostic screenings, but, according to the Partnership for Prevention, many Americans fail to take advantage of opportunities to get those screenings.

One of my recent blog postings – at mikecritelli.com – talked about how many of our societal laws and decisions create environments that make our citizens less healthy with respect to chronic diseases. One high leverage points in attacking the obesity problem is getting agricultural food subsidies changed. We tend to blame individuals for their eating habits, particularly obese low-income people. What we fail to understand is the extent to which both the availability and cost of foods is heavily influenced by long-standing agricultural subsidies imbedded into federal laws and U.S. Department of Agricultural regulations. Most unhealthy food our children eat during school is driven by Department of Agriculture policies that increase the use of grains and sugars in lunchtime meals. When you add the impact of cutbacks in school physical education programs, it is no wonder that the rates of obesity are rising, and that we are spending more on related illnesses.

Since our health care crisis is a result of declining health, which manifests itself in more chronic and infectious diseases, what do we do about it?

At Pitney Bowes, we have created the equivalent of a controlled test over the last 17 years to answer that question. The first critical insight was that if we aggressively created a culture of health, as opposed to focusing primarily on

managing our own health care costs, we would improve health and reduce health care costs. That, in turn changed our health care investment priorities, our plan design, and our overall approach to health.

Before I discuss the specifics of what we did, let me tell you a little about our demographics. 69% of our 26,000 U.S. employees work remotely, spend large amounts of their time traveling to and from customer sites, or are based on customer sites. Our workforce mirrors the American population, with 42 being the average age of the active benefit eligible employee, and more complex, chronic illnesses.

The net result of our demographics is that our 26,000-employee U.S. population is really two different populations of roughly equal size. Population 1 resembles the demographics of a large employer, that is, all employees either work on, or report to, sites we control, and many of those sites have sufficient scale that we can support free on-site clinics, cafeterias, and fitness centers.

Population 2 resembles the demographics of a collection of small businesses. Employees work in small concentrations on hundreds of customer sites or in mail processing centers. For this population, we do not have sufficient scale to provide the range of on-site services that our larger concentrations of employees enjoy such as nutritionally-conscious cafeterias. Moreover, the second population is primarily lower-wage workers and a higher percentage come to us less healthy, less educated about their health, and with less convenient access to health care. Thus, although we are a small slice of America, we have a total population that is remarkably representative of the

American public, and I believe our experience is scalable to the larger national health care policy debate.

While this discussion of what we have done will focus on Population 1, we are exploring ways to adapt and deliver the best of our successful practices to Population 2, and to our growing group of mobile and remote workers within Population 1. Use of the web and Internet technologies, partnerships with local/regional health care facilities, and utilization of mobile health services are just some of the ways that we are looking to deliver health information and services to our entire workforce.

We have four levers to improve health, some of which are available to both of our populations:

- We deliver several health enhancement, preventive care, and employee assistance programs to our entire population through our own staff and third-party providers.
- For our large business population, we deliver clinical care, as well as providing a total work environment focused on nutrition, fitness, and lifestyle improvement.
- We drive both populations toward healthy behaviors by designing and negotiating for health plans that create incentives for healthy and prudent health care behaviors and penalties for unhealthy or imprudent uses of the health care system.
- We insure that all of our employees have affordable, high-quality health plan choices from high-quality providers, wherever they live in America.

Therefore, because our first core strategy is to deliver programs that maximize health, our first programmatic intervention is with respect to pre-natal care. Our Great Expectations program has enabled us to focus on building that culture of health in a family even before birth, with the result that we have significantly reduced the frequency and the seriousness of pre-natal problems. For over 15 years, we have covered well-baby and well-child care, and have provided health information tools to help families understand and use nutrition and fitness for developing healthy children.

For our adult covered population, we have broad-based programs to promote healthy behaviors. We designed a program called Health Care University (HCU) to incent healthy lifestyles through reduced benefit costs. HCU features a curriculum of health education initiatives and healthy lifestyle programs in everything from stress reduction to disease management, each with a designated number of credits for successful completion that reduce out-of-pocket costs for benefit coverage. Those completing a wellness assessment and completing several recommended behavioral changes – such as reducing their BMI, exercising several times a week, wearing seatbelts and drinking more water receive credits as well. We expanded Health Care U to dependents through eHealth portals.

Our seasonal emphasis on fighting flu is a great example of ways that we are seeking to serve our entire covered U.S. workforce, and a great example of our approach to developing a culture of health. Approximately one month ago every employee received a "Flu Fighter" newsletter at home. We believe that it is important to equip employees with the information that they

need to manage their own health, and that direct mail about health and benefit issues sent to their home address is an effective way to reach employees and their loved ones. It also has the benefit of raising awareness of health issues within the household. Employees' loved ones can be important influences on their health choices and lifestyles and vice versa. If the employee is healthy, but their loved ones are ill, while they may be present physically, they tend to be less productive and less focused at work. By equipping the employee to support the health of those that they care about, we are also supporting their ability to stay fully engaged, while they are at work.

The newsletter featured information about why controlling flu is important, tips to stay healthy during flu season, guidelines on who is at high risk for getting the flu, and the difference between seasonal flu and pandemic flu. The newsletter also included information about 35,000 off-site locations where employees can get free flu shots, and about 30 on-site locations hosting free flu shot clinics. We also provided phone and Internet registration to find the flu shot location closest to you, and to receive the flu shot coupon for the off-site locations. As I discussed earlier, we believe that prevention is key, and immunizations and screenings are an important part of prevention, as I will discuss. We also feel very strongly that convenient access to affordable care removes the barriers to preventive care.

This example illustrates that, in addition to making targeted health promotion and illness and injury prevention programs available and affordable, we need to use both aggressive and targeted marketing outreach and education programs that will reach the broadest possible population. It

also demonstrates the need to provide flexibility both in how we communicate, and in the options that we give plan participants for responding to calls to action and for accessing services. The broader lesson for national health care policy is that, beyond universal, affordable coverage, there are three other prerequisites for achieving a culture of health throughout society:

- Convenient access to providers;
- Aggressive and customized marketing outreach to target populations; and
- Tailored education campaigns that persuade these populations to take control of their health.

Both the marketing and educational outreach also needs to be accomplished in a context in which the social aspects of health care are taken into account. For example, in a family unit, the care-giving spouse often drives health care decisions for the rest of the family unit. In other populations, friends and office mates induce individuals to seek out help. Any health care policy needs to recognize this and leverage it to improve health.

For behavioral health conditions, we provide a number of free consultations through our employee assistance program to give employees incentives to work with us to find the appropriate provider rather than having them automatically look for the fastest treatment plan. This is particularly important for substance abuse treatment. We believe that using "gatekeeping" programs like this is most effective when it is made financially more attractive, not when plan providers eliminate choices for patients.

The **second lever** for achieving a culture of health is creating a total environment that promotes and reinforces healthy behaviors. For employees working at our larger sites we have:

- Cafeterias that serve appropriate portions of nutritious food and beverages, and pricing, marketing and merchandising practices drive employees to eat the healthy food.
- Fitness centers in several of our facilities and discounts for outside fitness center memberships. We also give benefit premium discounts for employees that participate in fitness programs like the 10,000 steps-a-day walking program.
- We have had smoke-free workplaces since 1990, and offer on-site smoking cessation programs, with free related-medication.

Proper nutrition, appropriate levels of exercise and fitness, addressing unhealthy lifestyle issues like smoking in the worksite environment all promote a culture of health in the environment in which most adults spend the largest part of the waking hours. The lesson for the national health care debate is that any meaningful health care reform proposal has to give employers an incentive to help employees take better care of their health. Government, insurance, or consumer-centric proposals, while meritorious in many respects, all need to include components that make the employer a partner in health promotion if they are going to solve the underlying health cost problem.

We also provide clinical services wherever and whenever we can assemble a critical mass of those we cover in our plans.

- We have a network of six on-site medical centers in our major population facilities across the country staffed by an array of medical personnel including physicians. We also provide space inside our clinics for specialists who have many employees as patients. We handle an average of 35,000 patient visits annually in our clinic network. In the next few months, we will be opening two more clinics.
- These clinics are free of charge for employees and are open every workday.
- We can generally give them free medications to treat their minor acute illnesses and injuries. For more serious conditions, we help guide them to the right kind of local medical provider. We also make valuable preventive screenings and immunizations free or as low-cost as possible.
- We also have a pharmacy managed by Caremark, our pharmacy benefit manager, adjacent to our World Headquarters; available to anyone we cover under our health plans. Employees at other nearby locations can order prescriptions that are delivered to their location on a daily basis.
- We do outreach to our employees and retirees to provide screenings and immunizations outside our clinics, either at their facilities or at other sites where they have gathered for special events.

Do not underestimate the value of immunizations and health care screenings in the culture of health. This is a great opportunity for employers to make a difference. Even if businesses cannot go as far as we do, in terms of

providing on-site screening or immunizations, they can look at ways to partner with local health providers or inform employees about ways to access these services within the community.

These clinics have benefited us as well as the employees for a variety of reasons:

- Employees have access to clinical care for minor illnesses and injuries without having to leave the office, and without long waiting times.
- In fact, employees who have non-contagious conditions will come to work to use the clinic, rather than making a discretionary decision to stay home for the day to access their private care physician. Our savings are enough to cover the cost of the on-site medical care facilities and staff.
- By referring patients to primary care physicians or specialists we help them develop a relationship with a physician, and make them better-informed users of the health care system. We work closely with their primary care physicians in the community to make sure we provide complementary service, not a competitive one.

Two broad lessons from our clinical care experience:

- Convenient access to medical care is as important as universal affordable coverage. There are two different access challenges. The first is the challenge of providing primary care at or near the workplace, so that employees do not lose several hours getting treated for a minor

medical condition or getting an immunization or screening. The second is the challenge of after-hours care. Too many communities in this country have no after-hours care except for emergency rooms. We need care seven days a week in convenient locations accessible to large populations. Absent convenient access, patients will see physicians only when they are very sick. Absent convenient access, we will continue to see an underutilization of screenings and immunizations that would prevent diseases or detect them at early, more treatable stages.

- Our experience with the clinics also reinforced our belief in the benefit of continuity of care, and the need for portable, patient-controlled electronic health information to optimize health and disease management. This led us to our involvement of Dossia, of which I am Chairman. Dossia is a consortium of large employers including Pitney Bowes and Intel, funding the development of a personal, portable electronic health record. Health providers need to have a more unified understanding of the patient's health and history. We believe that a comprehensive understanding of an individual's health treatments and trends enhances the quality of care, enhances the operating efficiency of health care providers, and, most importantly, empowers individuals to assume greater control over their health. We are

excited about the possibilities to enhance health that Dossia can bring.

The initiatives that I have described to you thus far helped move our employee population toward better health and keep our costs flat for a decade. When we saw the unanticipated big jumps in health costs in 2000, however, we knew we needed a more robust understanding of what was driving the change.

Our next phase of innovation in the delivery of health was data-driven and linked to trends within our population, and it led us to use **the third lever**: crafting health plan designs that drove the right kinds of patient behaviors.

We did an assessment of the most prevalent conditions within our workforce, the behaviors that supported prevention or management of these conditions, and their cost implications. We saw a pattern where employees incurred minimal to no costs for health, and then within 12 months were incurring costs in excess of $10,000.

We found a strong association between chronic condition progression and low possession rates of medication, lack of preventive screening, and use of care management programs. For example, if an individual diagnosed with diabetes has filled less than 9 prescriptions for diabetes drugs in the preceding year, then in the following year, their cost of care will probably significantly increase. Another marker was the absence of health care spending in the previous year, indicating that no routine checkups or screenings were performed.

Traditionally an employee with a chronic disease is deemed a risk. Our findings revealed that the real risk is in not actively screening for early warning signals, or managing treatment and progression once confirmed.

This analysis also really helped us understand the relationship between compliance and costs, and in particular the impact on pharmaceutical regimens. What makes the employee delay treatment and forego compliance thereby worsening their condition? We found that the biggest driver was cost. The vicious cycle of cost is that it exacerbates non-compliance, which accelerates deterioration, and ultimately drives up total cost of care -- which includes inpatient/outpatient services, pharmacy, disability and absenteeism.

Lack of adherence to treatment plans costs America more than $100 billion annually in unnecessary acute care, adding over 5% to our health care cost burden.

Thus, in 2002 our modeling led us to remove the barriers to screening and adherence to treatment of chronic diseases by taking on more of the cost, so that the employee would pay less. That included expanding Tier 1 coverage for generic prescriptions and all brand name prescriptions for targeted conditions such as asthma, diabetes and hypertension. The average cost for a 30 day supply of any of the designated pharmaceuticals is 50-80% lower than it was prior to initiation of this program. We also dropped the price of supplies, lowered or eliminated costs for preventive services, and we provided first dollar coverage for routine services.

We are excited about the results. Since dropping the cost on all diabetes medications and supplies, we have seen purchase/use of medicines double; use of emergency rooms dramatically decrease; and lost time related to disability was cut by 50%. Relative to asthma treatment hospital admissions are down by 20%, and our overall costs down by 20%.

Overall, we have seen improved adherence to pharmaceutical therapies, and better management of the conditions as reflected in the types of medications that employees are purchasing which are more in the "controller" category rather than the "rescue" category associated with emergencies.

We also learned that, in certain communities, plan designs need to be customized to counteract supply-driven demand. For example, we found that in some communities, an increased supply of MRI equipment led to an overuse of MRI's as a diagnostic tool. We addressed that issue by raising co-pays for MRI tests to make the patient a partner in addressing the overuse issue. We might have used a pre-certification process as well, and, today, we use that for referrals to specialists.

The overriding lesson from our dialogue today is that plan designs drive behavioral changes. We get the behaviors our plans incent and we see fewer of the behaviors our plans penalize. We need to make sure that our plan design drives decisions consistent with our plan objectives of keeping healthy people healthy, getting those at risk to become actively engaged in prevention, and getting those with chronic diseases involved in its aggressive management.

The other broad implication of the importance of a plan design that is continually modified based on behavioral responses to it is that the two worse venues for specific health plan design are state and federal legislative bodies and government regulators, including regulators with broad-based medical expertise like CMS. Legislative mandates, even if correct at the time they are implemented, are exceptionally difficult to reverse if behavioral responses produce dysfunctional results later. Even expert regulators must take many years and get broad-based input to make even the most sensible changes, especially when staffing and budgets on plan design review processes are highly constrained.

The **fourth lever** for delivering better health is our ability to select the best available health plan alternatives for our employees, and give them meaningful choices for their health insurance coverage. By using tools like “eValu8” and Bridges to Excellence, and joining associations like the New York Business Group on Health and the Leapfrog Coalition, we have given our employees better leverage than they could have got on their own. We also identify in each of our health plan the right centers of excellence for high-cost acute care conditions.

My Vision for a National Health Policy

Based on what we have seen succeed at Pitney Bowes, I think the end goal of a national health policy has to be based on the maximization of the health, quality of life, and productivity for all Americans. We must prioritize investment in wellness, prevention, as well as early diagnosis, treatment and aggressive management of chronic conditions.

The essential elements of the national policy must revolve around:

- Enabling and incenting healthy behaviors,
- Convenient, 24x7 access to appropriate quality care,
- Universal coverage at affordable rates, and
- A high quality health system focused on continuous improvement.
- Plan designs that drive patients to engage in healthy behaviors, adhere to appropriate treatment plans, and select best-in-class providers.

The key principles of the health system would include:

- Americans need to know how to engage in healthy behaviors, and to be in a healthy environment that encourages healthy behaviors.
    - We must be aware of the effect of governmental actions, such as subsidies, on the average American's ability to engage in healthy behaviors.
    - A comprehensive private, patient-controlled electronic health record is an essential tool for a world-class health care system, particularly in getting individuals to take better control over their health.
- Americans need convenient access to the right providers, the right technologies and processes for health monitoring and improvement, and the right information. The right providers, in many instances, are either primary care physicians, nurse-practitioners, or nurses. Our health care policy needs to focus on rewarding these practitioners to put them collectively at an appropriate relationship with specialists who are amply rewarded today.

- We need universal, affordable, comprehensive health care coverage, and everyone needs to have that coverage.
- Health care plans need to incent healthy behaviors and disincent unhealthy behaviors.
    - Plan providers and payers need to understand the behavioral consequences of plan designs, such as the link between higher prescription drug costs and non-adherence to treatment
    - The plans must have education and marketing outreach, and strong financial incentives. In particular, plans need to recognize that we are a diverse country of many different population segments with different medical needs, best reached by different marketing channels, with receptivity to different kinds of messages.
- The health care system needs to be high quality and health plans should reward quality care. To deliver sustainable quality, the health system must have the capacity for continuous improvement, consistent with Six Sigma principles.
    - Meaningful competition for providers at the level of primary and specialist care for specific medical conditions, and complementary and alternative medicine can enhance the quality of overall care.
- Employer-based health plans have a unique and valuable role to play in any system.

Conclusion

We believe in the value and the power of a culture of health. The journey to develop and maintain a culture of health is a marathon, not a sprint. It starts

with a focus on optimizing health, and the willingness to make investments, that will have returns over time. I have appreciated the opportunity to share our experience with you today. I would now be happy to engage in a discussion and take your questions.